Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management - Utilization Management**		**<u>SUBJECT (Document Title)</u>** **Pediatric Day Health Care and Personal Care Services - LA**	
Effective Date November 12, 2018	**Date of Last Review** July 19, 2023	**Date of Last Revision** ~~July 19, 2023~~ February 21, 2024	**Dept. Approval Date** ~~July 19, 2023~~February 21, 2024
<u>Department Approval/Signature:</u>			

<u>Policy applies to health plans operating in the following State(s). Applicable products noted below.</u>

<u>Products</u>				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

<u>POLICY:</u>

To provide guidance for the administration of pediatric day health care (PDHC) and personal care services (PCS) consistent with standards set forth by the Louisiana Department of Health (LDH), and to ensure services offered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program are provided in the most appropriate, cost-effective, and least restrictive setting, compatible with medical necessity as determined by the severity of illness and/or the intensity of the services needed to contribute to an improved health status. PDHC and PCS are covered benefits when medical necessary for beneficiaries under twenty-one (21) years of age.

<u>DEFINITIONS:</u>

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Activities of Daily Living (ADL) – Those daily activities that are required by an individual for continued well-being, health, and safety. The function or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. ADLs include bathing, dressing, eating, grooming, walking, transferring, and/or toileting. The extent to which a person requires assistance to perform one (1) or more of these activities is often a level of care criterion.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Medicaid's comprehensive and preventive child health program for individuals who are under the age of twenty-one (21). All medically necessary Section 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible beneficiaries ages birth to twenty (20), in accordance with 42 United States Code (USC) §1396d(r). This includes but is not limited to, conditions which are discovered through EPSDT Well Child screening services, whether or not such services are covered under the Medicaid State Plan (42 USC

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§1396d(r)(5) and the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual).

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries. The EVV system helps to ensure that beneficiaries are receiving services authorized in their plan of care (POC), reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Louisiana Service Reporting System (LaSRS) – LDH's electronic visit verification (EVV) system for providers of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) personal care services (PCS). Utilization of an EVV system is a federal requirement that applies to all managed care EPSDT-PCS providers.

Medically Complex Condition – A medically complex condition involves one (1) or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

NOTE: The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services, does not in itself make such care, goods or services medically necessary, or a covered service. Medicaid reimburses for services that are deemed medically necessary, do not duplicate another provider's service and meet the following conditions:

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- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid Program and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative, more integrated or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker or the provider.

Pediatric Day Health Care (PDHC) – An array of services to meet the medical, social and developmental needs of children from birth up to twenty-one (21) years of age who have a complex medical condition which requires skilled nursing care and therapeutic interventions on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC is to serve as a community-based alternative to long-term care and extended in-home nursing care. PDHC does not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care. PDHC is intended to be for individuals needing a higher level of care that cannot be provided in a more integrated community-based setting.

Personal Care Services (PCS) – Tasks provided by direct service workers that are medically necessary as they pertain to an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible's physical requirements when physical or cognitive limitations due to illness or injury necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements, and these services prevent institutionalization and enable the beneficiary to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost-effective than services provided on an inpatient basis. PCS does not include medical tasks such as medication administration, tracheostomy care, feeding tubes, or catheters.

Plan of Care (POC) – – For intents and purposes of this policy, a POC is a person-centered, individualized, comprehensive written document developed by the beneficiary, his/her authorized representative, and provider based on assessment results. The document identifies each service area and outlines how services will be delivered to a beneficiary based on his/her preferences. Strategies are designed to guide health care professionals involved with patient care. Such plans are patient-specific and meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

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- For example, it is a comprehensive plan developed by the pediatric day health care (PDHC) facility for each child to receive medical, nursing, psychosocial, developmental and educational therapy services, in conjunction with the beneficiary (or parent/guardian) that outlines how services will be delivered to the beneficiary and support achievement of care goals.

Prior Authorization (PA)– Medical necessity review of a healthcare service, treatment plan, equipment, or prescription drug that is prospective or conducted prior to the member's utilization of service or course of treatment in a hospital or other facility. Also referred to as prospective review, (PA), prior approval, precertification or preauthorization.

PROCEDURE:

Pediatric Day Health Care

Healthy Blue complies with the *Pediatric Day Health Care Provider Manual* chapter of the *Medicaid Services Manual*.

Pediatric day health care (PDHC) provides an array of services to meet the medical, social, and developmental needs of children from birth up to twenty-one (21) years of age who have a complex medical condition which requires skilled nursing care and therapeutic interventions on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC is to serve as a community-based alternative to long-term care and extend in-home nursing care. PDHC is intended for individuals needing a higher level of care that cannot be provided in a more integrated community-based setting.

The PDHC per diem rate includes the following services/equipment:

- Nursing care;
- Respiratory care;
- Physical therapy (PT);
- Speech-language therapy (ST);
- Occupational therapy (OT);
- Social services;
- Personal care services (PCS) for activities of daily living (ADL); and
- Transportation to and from the PDHC facility (paid in a separate per diem).

PDHC providers are not allowed to send beneficiaries to outside sources to receive the above services. Healthy Blue ensures strict adherence to this requirement to prevent duplicate payment of services and to ensure compliance.

Excluded Services – Services Not Covered:

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The PDHC per diem rate does **not** include the following services:

- Education and training services
- Before and after school care;
- Respite services;
- Childcare due to work or other parental time constraints;
- Medical equipment, supplies and appliances;
- Parenteral or enteral nutrition; and
- Infant food or formula.

PDHC does not provide respite care and is not intended to be an auxiliary (back-up) for respite care. Parental or guardian availability cannot be used as a factor in the determination of authorization for services.

Recipient Criteria:
To be eligible for PDHC services, the beneficiary must require nursing supervision and possible therapeutic interventions due to a medically complex condition. The determination for services is based on medical necessity and may consider other services currently provided or available to the member. In order to qualify for PDHC services, a beneficiary must meet all of the following criteria:

1) Be Louisiana Medicaid eligible;
2) Be from birth up to twenty-one (21) years of age;
3) Have a medically complex condition which involves one (1) or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions, and/or prolong life;
4) Be a candidate for outpatient medical services in a home or community-based setting; and
5) Have a signed physician's order and POC by the beneficiary's physician specifying the frequency and duration of services.
    - The POC must clearly outline the skilled nursing care and therapeutic interventions that will be performed in the PDHC facility.
    - The POC must be individualized, specific and consistent with the symptoms or confirmed diagnosis of the disease, condition, or injury under treatment, and not in excess of the beneficiary's needs.

Authorization Requirements:
All PDHC services must be prior authorized. Services may be provided seven (7) days per week and up to twelve (12) hours per day for qualified Medicaid beneficiaries as documented in the plan of care (POC).

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Section (Primary Department) **Health Care Management - Utilization Management**	**SUBJECT (Document Title)** **Pediatric Day Health Care and Personal Care Services - LA**

Reimbursement for pediatric day health care (PDHC) services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified beneficiary attends the PDHC facility. Transportation to the facility will be reimbursed separately, according to the following:

- A full day of service is more than six (6) hours, not to exceed a maximum of twelve (12) hours per day, and reimbursed on a per diem basis (T1025).
- A partial day of service is equal to six (6) or fewer hours per day and reimbursed on an hourly basis (T1026). PDHCs may only bill an additional hour of skilled services if thirty (30) or more minutes of care has been provided.
- For full and partial days, PDHCs must document in the clinical record the start and end time that skilled services were provided.
- If a beneficiary is approved for full days of services, partial hours will be automatically generated with the PA for a percentage of the number of full days approved. Partial hours should be used when the child cannot attend for the full day, so that the provider can bill for the actual service hours less than six (6) hours.
- Transportation is reimbursed in a separate per diem (T2002). Transportation time is not included in determining reimbursement of hours spent at the PDHC. The transportation benefit is part of PDHC program rather than the non-emergency medical transportation (NEMT) program.
- For reimbursement purposes, PDHC services begin when the PDHC staff assumes responsibility for the care of the child and ends when care is relinquished to the parent or guardian.
- Reimbursement is only made for services that have been prior authorized by Healthy Blue.

PDHC services require prior authorization (PA) and must be approved prior to the delivery of services. ~~The PDHC PA form is standardized regardless of the health plan covering the services.~~ To receive PA, the following documentation must be sent for each request:

- ~~Standardized PA form which must include why the services provided at the PDHC cannot be provided elsewhere, including the school system;~~Completed PA Form
- The physician's order and POC for PDHC;
- The physician's most recent note(s) documenting medical necessity for PDHC;
- The PDHC PA checklist indicating the beneficiary's skilled nursing care requirements; and
- Medical records needed to establish medical necessity and support orders and POC.

Services shall be ordered by the beneficiary's prescribing physician. In the event, the medical director of the PDHC facility is also the beneficiary's prescribing physician, the order and POC will be reviewed by Healthy Blue for the recommendation of the beneficiary's participation in the PDHC program.

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A face-to-face evaluation between the beneficiary and prescribing physician must be held every ninety (90) days. In exceptional circumstances, at the discretion of the authorizing Medical Director, the face-to-face evaluation requirement may be extended to one hundred eighty (180) days.
The physician's order for services is required to individually meet the needs of the beneficiary and shall not be in excess of the beneficiary's needs. The order shall contain:
1) The beneficiary's name;
2) Date of birth;
3) Sex;
4) Medicaid ID number;
5) Description of current medical conditions, including the specific diagnosis codes;
6) The parent/guardian's name and phone number; and
7) The provider's name and phone number.

The physician shall acknowledge if the beneficiary is a candidate for outpatient medical services in a home or community-based setting. The physician shall sign, date, and provide his/her National Provider Identifier (NPI) number. Specific medical records may be requested from the physician.

Necessity for PDHC services will include consideration of all services the beneficiary may be receiving, including waiver services and other community supports and services. These services must be reflected and documented in the beneficiary's treatment plan.

The approval period may not exceed ninety (90) days. Re-evaluation of PDHC services are performed, at a minimum, every ninety (90) days. At the discretion of the authorizing Medical Director, exceptions to the ninety (90) day standard may be made. Services shall be revised during evaluation periods to reflect accurate and appropriate provision of services for current medical status. This evaluation must include:
- A review of the beneficiary's current medical POC;
- A provider agency documented current assessment and progress toward goals;
- Documentation of a face-to-face evaluation between the prescribing physician and beneficiary held every ninety (90) days (in exceptional circumstances, at the discretion of the authorizing Medical Director, the face to face evaluation requirement may be extended to one hundred eighty (180) days;
- A completed PA form; and
- A completed PDHC PA checklist indicating the beneficiary's skilled nursing care needs.

Healthy Blue will review the forms to determine the documentation is complete and that services continue to be medically necessary and appropriate to reauthorize the services.

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Note: An approved PA is not a guarantee that Medicaid or Healthy Blue will reimburse the service. The provider and beneficiary must both be eligible on the date of service, and the service must not exceed the weekly approved hours.

PDHC providers shall submit a claim for payment for prior authorized services, after the service has been provided. In order to receive reimbursement for the service, the provider must enter the PA number on the claim form. Services provided without prior authorization shall not be considered for reimbursement. Services shall be billed as described by Healthy Blue.

Parental/Guardian Consent:
Signed parental/guardian consent is required for participation in PDHC. The consent form shall outline the purpose of the facility, parental/guardian's responsibilities, authorized treatment and emergency disposition plans. A conference shall be scheduled prior to admission with the parent/guardian(s) and the PDHC representative to develop the POC based upon documentation of medical necessity provided by the physician.

If the beneficiary is hospitalized at the time of the referral, planning for PDHC participation shall include the parent/guardian(s), relevant hospital medical, nursing, social services and developmental staff to begin the development of the POC that will be implemented following acceptance to the PDHC facility.

Plan of Care:
The individualized POC addressing the beneficiary's medically complex condition, goals, skilled nursing care and therapeutic interventions needed to achieve the desired outcomes shall be developed under the direction of the facility's nursing director in collaboration with the prescribing physician prior to placement in the facility. The POC shall ensure the beneficiary's skilled nursing care and therapeutic needs are addressed, identify specific goals for care and plans for transition to discontinuation of care. The POC must be signed by the parent/guardian, PDHC representative, and prescribing physician. A copy shall be given to the prescribing physician and to the parent/guardian if requested. The facility shall retain a copy in their records. Services shall be administered in accordance with the POC. The POC is written to cover a specific timeframe. The plan for achieving the goals shall be determined and a schedule for evaluation of progress shall be established.

The development of the plan shall begin within seventy-two (72) hours of the referral. A POC is required prior to the first day PDHC services begin. The beneficiary's treatment plan must consider and reflect all services the beneficiary is receiving, including waiver and other community supports and services. The POC for continuation of services shall be reviewed and updated, at a minimum, every ninety (90) days or as indicated by the needs of the beneficiary.

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The initial POC should consist of the following components:
1) Provider Information – name and Medicaid provider number;
2) Start of care date and certification period;
3) Beneficiary's functional limitations, rehabilitation potential, mental status, level of activity status, precautions, method of transportation to and from facility and allergies;
4) Other special orders/instructions;
5) Medications, treatments and any required equipment;
6) Monitoring criteria, monitoring equipment and supplies;
7) Nursing services to be provided;
8) Diet as indicated and how beneficiary is to be fed;
9) Beneficiary's current medical condition and hospitalizations within last six (6) months;
10) Risk factors associated with medical diagnoses;
11) Special goals for care identified – plans for achieving the goals shall be determined and an evaluation schedule of progress shall be established;
12) Frequency/duration of PDHC services – number of days/week, hours/day and anticipated duration;
13) All services the beneficiary is receiving, including waiver and other community supports and services must be considered and reflected; and
14) Discharge plans – contain specific criteria for transitioning from or discontinuing participation in the PDHC program with the facility.

The POC must be signed by the prescribing physician, an authorized representative of the facility, and the beneficiary's parent/guardian. All signatures on the POC must be legible and dated. The facility staff shall administer services and treatments in accordance with the POC as ordered by the physician.

For recertification, accomplishments toward goals, assessment of effectiveness of services, acknowledgment of face-to-face evaluation between beneficiary and prescribing physician every ninety (90) days. In exceptional circumstances, at the discretion of the Medical Director authorizing PDHC services, the face-to-face evaluation requirement may be extended to one hundred eighty (180) days.

For continuation of services, the POC shall include the above components. In addition, the renewal must:
- Be reviewed and updated, at a minimum, every ninety (90) days or as indicated by the needs of the beneficiary;
- Consider and reflect all services the beneficiary is receiving, including waiver and other community supports and services;
- Be completed by a registered nurse of the facility;
- Be reviewed and ordered by the prescribing physician:

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- The PDHC facility shall send medical documentation to the referring physician that demonstrates services rendered as well as progress reports on the child;
- Physician shall provide updated medical information and progress notes from the required face-to-face visits;
- The physician will certify ~~on the prior authorization form~~ that he/she has read the progress report from the previous period; and

- Be incorporated into the beneficiary's clinical record within seven (7) calendar days of receipt of the prescribing physician's order.

The PDHC facility's medical director shall review the POC in consultation with the PDHC staff and the prescribing physician every ninety (90) days or more frequently as the beneficiary's condition dictates. Prescribed services and therapies included in the POC shall be adjusted in consultation with the prescribing physician to accommodate the beneficiary's condition.

Medical Records:

Each beneficiary shall have a medical record developed at the PDHC facility at the time of acceptance and maintained throughout care of the beneficiary. The beneficiary's medical record must be signed by authorized personnel and contain at least the following documents:

- Medical plan of treatment and nursing POC;
- Referral and admission documents;
- Physician orders;
- Medical history;
- Immunization documentation;
- Medication/treatment administration record;
- Case notes;
- Documentation of nutritional management and diet;
- Documentation of physical, occupational, speech and other therapies;
- Correspondence concerning the beneficiary;
- An order written by the prescribing physician if the beneficiary terminates services with the facility, if applicable; and
- A summary including the reason for termination, if applicable.

Durable Medical Equipment (DME):

The Medicaid Program nor Healthy Blue will reimburse a PDHC for DME and supplies that are provided to the beneficiary through the DME program.

Medications

The parent or guardian is to supply medications each day as prescribed by the beneficiary's attending physician or by a specialty physician after consultation and coordination with the PDHC facility. PDHC staff shall administer these medications, as ordered or prescribed, while the beneficiary is on-site.

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The medications shall be kept in their original packaging and contain the original labeling from the pharmacy, and be individually stored in a secure location at the appropriate temperature recommended.

Each PDHC facility shall maintain a record of medication administration. The record shall contain:

- Each medication ordered and administered;
- The date, time and dosage of each medication administered; and
- The initials of the person administering the medication.

The facility shall have established policies and procedures for the handling and administration of controlled substances. Schedule II substances shall be kept in a separately locked and secure box, in a secured designated area.

Transportation

The PDHC facility shall provide or arrange transportation of the beneficiary to and from the facility; however, no beneficiary, regardless of his/her region of origin, may be in transport for more than one hour on any single trip. The PDHC facility is responsible for the safety of the beneficiary during transport. The family may choose to provide their own transportation. Providers who offer transportation or contract transportation with an agency must adhere to all of the rules and regulations outlined in the PDHC Facilities, Licensing Standards governing transportation. Transportation to and from the PDHC facility is reimbursed at a daily per diem on a per case basis in accordance with 42 CFR 440.170(a).

All transportation provided by a PDHC facility must meet the standards for commercial transport as specified under the Americans with Disabilities Act (ADA) and the U.S. Department of Transportation (DOT) regulations. The beneficiaries may not be transported in a private vehicle owned or operated by any employee and/or owner. The transporting vehicle must be licensed in the state and meet all vehicle inspection criteria. Appropriate insurance is required according to state laws.

The driver and one (1) appropriately trained staff member shall be required at all times in each vehicle when transporting any beneficiary. Staff shall be appropriately trained on the needs of each beneficiary, and shall be capable and responsible for administering interventions when appropriate. All contracted transportation providers must meet the same standards if the purpose of the contract is to transport beneficiaries to any PDHC facility.

The parent/guardian shall provide a signed authorization designating the person(s) the beneficiary can be released to for transportation purposes. The authorization shall provide the location where the beneficiary can be picked up or dropped off. The release shall name the facility and to whom the beneficiary shall be released.

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The driver or attendant shall be provided with a current master transportation list including:
- Each beneficiary’s name;
- Pick up and drop off locations; and
- Authorized persons to whom the beneficiary may be released to.

An attendance record shall be maintained by the driver or attendant for each trip. The record shall be signed by the driver or attendant and the PDHC representative who accepts and releases the beneficiary each day. The record shall include the following:
- Driver’s name;
- Date of the trip;
- Names of all passengers (beneficiary and adults) in the vehicle; and
- Name to whom the beneficiary was released to and the time of the release.

The PDHC facility shall maintain an attendance record for each trip. The record shall include:
1) Method used to transport the beneficiary to and from the facility;
2) Name of the person transporting the beneficiary;
3) Date and time of the trip release; and
4) Signatures of the driver or parent/guardian and the PDHC representative.

Each beneficiary shall be safely and properly:
1) Assisted into the vehicle;
2) Restrained in the vehicle;
3) Transported in the vehicle; and
4) Assisted out of the vehicle.

The driver or appropriate staff person shall check the vehicle at the completion of each trip to ensure that no beneficiary is left in the vehicle. Appropriate staff person(s) shall be present when each beneficiary is delivered to the facility.

Provider Requirements:
The PDHC facility must have a valid, current PDHC license issued by LDH. LDH is the only licensing authority for PDHC facilities in the state of Louisiana. Each facility shall be separately licensed. A parent or legally responsible person providing care to a medically complex child in his/her home, or any other extended care or long term care facility, is not considered a PDHC facility and will not be licensed as a PDHC facility.

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PDHC facilities must adhere to all staffing and personnel guidelines outlined in the Licensing Standards for PDHC facilities.

PDHC facilities are responsible for maintaining personnel records and patient medical records. All PDHC facilities must have a quality assurance program and conduct quarterly reviews of the facility's medical records for a minimum of one-fourth of the beneficiaries served by the facility at the time of the assurance review.

EPSDT Personal Care Services

Healthy Blue complies with the *Personal Care Services Provider Manual* chapter of the *Medicaid Services Manual* and additional requirements of the *MCO Manual*.

Personal Care Services (PCS) are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.

By definition, PCS does not include any medical tasks such as medication administration, tracheotomy care, feeding tubes, or catheters. PCS does not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care.

PCS include the following tasks:

- Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with dressing;
- Assistance with bladder and/or bowel requirements or problems, including helping the beneficiary to and from the bathroom or assisting the beneficiary with bedpan routines, but excluding catheterization;
- Assistance with eating and food, nutrition and diet activities, including preparation of meals for the beneficiary only;
- Performance of incidental household services, only for the beneficiary, not the entire household, which are essential to the beneficiary's health and comfort in his/her home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the beneficiary. Examples of such activities are:
  - Changing and washing the beneficiary's soiled bed linens;
  - Rearranging furniture to enable the beneficiary to move about more easily in his/her own home; and
  - Cleaning the beneficiary's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the beneficiary only.
- Accompanying, not transporting, the beneficiary to and from his/her physician and/or medical appointments for necessary medical services.

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- Assisting the beneficiary with locomotion in their place of service, while in bed or from one surface to another; and assisting the beneficiary with transferring and bed mobility.

Excluded Services – Services Not Covered:

The following services are **excluded, not appropriate** for personal care, and **not reimbursable** as PCS:

- Custodial care or provision of only instrumental ADL tasks or provision of only one (1) ADL task;
- Cleaning of the home, floor, and furniture in an area not occupied by only the beneficiary (example: cleaning an entire living area or an area shared with other household members, if the beneficiary occupies only one (1) room);
- Laundry, other than that incidental to the care of the beneficiary (example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the beneficiary's clothing or bedding);
- Skilled nursing services as defined in the State Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;
- Specialized nursing procedures such as:
  - Insertion of nasogastric feeding tube;
  - In-dwelling catheter;
  - Tracheotomy care;
  - Colostomy care;
  - Ileostomy care;
  - Venipuncture; or
  - Injections;
- Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed);
- Irrigation of any body cavities which require sterile procedures;
- Home IV therapy;
- Administration of intradermal, subcutaneous, intramuscular or intravenous injections;
- Administration of medicine (the PCS worker may only remind or prompt self-administered medication for EPSDT eligible beneficiaries over eighteen (18) years of age);
- Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions;
- Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate, or severe skin problems;

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- Teaching a family member or friend how to care for a patient who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;
- Teaching a family member or friend techniques for providing specific care;
- Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;
- Specialized aide procedures such as:
  - Rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services);
  - Measuring/recording patient vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;
  - Specimen collection; or
  - Special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas;
- Rehabilitative services such as those administered by a physical therapist;
- Occupational therapy;
- Speech pathology services;
- Audiology services;
- Respiratory therapy;
- DME;
- Oxygen;
- Orthotic appliances or prosthetic devices;
- Personal comfort items;
- Drugs provided through the pharmacy program;
- Laboratory services; and
- Social work visits.

Intent of Services:

- Persons under the age of twenty-one (21), for whom the services are intended, must have a condition(s) that causes him/her not to be capable of completing at least two (2) age-appropriate ADLs. ADLs include eating, bathing, dressing, personal hygiene and bladder or bowel requirements.
- PCS is not to be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian.
- PCS is not to be used to provide respite care for the primary caregiver.
- PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or should be provided by the Department of Education.

Location of Services:

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PCS must be provided in the beneficiary's home or, if medically necessary, in another location outside the beneficiary's home. The beneficiary's home is defined as the beneficiary's own dwelling: an apartment, a custodial relative's home, a boarding home, a foster home, or a supervised living facility. Institutions such as a hospital, institution for mental disease, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or residential treatment center are not considered a beneficiary's home.

Service Delivery:
PCS providers may not provide services at the same time as other covered services, unless medically necessary. Medicaid prohibits multiple professional disciplines from being present in the beneficiary's residential setting at the same time. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists.

Children's Choice waiver services and PCS may be performed on the same date, but may not be performed at the same time. If the member is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider. Beneficiaries may receive hospice services on the same date as PCS, but not at the same time. The PCS and hospice providers must coordinate services and develop the patient's POC.

Recipient Criteria:
Criteria and conditions for provisions of PCS are as follows:

- Medicaid Eligibility:
  - The person must be a categorically eligible Louisiana Medicaid beneficiary birth through twenty (20) years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate PCS by a practitioner (physician, physician assistant, or advance practice nurse).
  - The practitioner shall specify the health/medical condition which necessitates PCS.
- Medical Necessity:
  - An EPSDT eligible must meet medical necessity criteria as established by ~~the Bureau of Health Services Financing (BHSF)~~ Healthy Blue which shall be based on functional and medical eligibility and impairment in at least two (2) age-appropriate ADL tasks~~, as determined by BHSF or its designee~~.
  - To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.
  - Emphasis must be placed on whether the child/youth is capable of completing the ADLs independently. Reminding or prompting the beneficiary to complete these daily tasks does not meet medically necessity for the service.

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- The provision of PCS is based on whether the child is able to perform two (2) or more age-appropriate ADLs. It is not based on whether the child has a physical disability.

- Physician Referral:
  - PCS must be prescribed by the beneficiary's attending practitioner initially and every one hundred eighty (180) days after that (or rolling six (6) months), and when changes in the POC occur.
  - The POC shall be acceptable for submission only after the practitioner signs and dates the completed form.
  - The practitioner's signature must be an original signature and not a rubber stamp.

Authorization and Service Limitations:
PCS must be prior authorized. Services are not authorized for more than a six (6) month period. Services may be provided up to seven (7) days per week as documented in the POC. A face-to-face medical assessment shall be completed by the practitioner. The beneficiary's choice of a PCS provider may assist the practitioner in developing a POC which shall be submitted for review/approval.

PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the beneficiary and medical necessity for the covered services. Hours may not be "saved" to be used later or in excess of the number of hours specified according to the approval letter.

All initial and subsequent PA requests for PCS must be accompanied by the following documents:

- Physician's referral for PCS;
  - PCS must be prescribed by the beneficiary's attending practitioner initially and every one hundred eighty (180) days after that (or rolling six (6) months), and when changes in the POC occur.
  - The prescription does not have to specify the number of hours being requested, but must specify PCS and not personal care attendant (PCA).
  - The practitioner's signature must be an original signature or a computer-generated electronic signature. Rubber stamped signatures are not accepted.
  - Signatures by registered nurses on the referrals are not acceptable.
- POC prepared by the PCS agency with practitioner's approval;
  - The provider may not initiate services or changes in services under the POC prior to approval by Healthy Blue.
- EPSDT-PCS Form 90;
  - Completed by the attending practitioner;
  - Completed within the last ninety (90) days;
  - Documents the beneficiary requires assistance with at least two (2) ADLs; and

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- Documents a face-to-face medical assessment was completed.
- EPSDT-PCS Daily Schedule ~~Form~~;
- EPSDT-PCS Social Assessment ~~Form~~;
- Completed prior authorization request form; and
- Other documentation that would support medical necessity (i.e., other independent evaluations).

Chronic Needs Case:
Beneficiaries who have been designated by Healthy Blue as a “Chronic Needs Case” are exempt from the standard PA process. A new request for PA shall still be submitted every 180 days; however, the provider shall only be required to submit a PA form accompanied by a statement from the beneficiary’s primary practitioner verifying that the beneficiary’s condition has not improved and the services currently approved must be continued. The provider must indicate it as “Chronic Needs Case” request. This determination only applies to the services approved where requested services remain at the approved level. Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request.
NOTE: Only Healthy Blue is allowed to grant the designation of a “Chronic Needs Case” to a beneficiary.

Plan of Care:
The POC must be ~~written on the current version of the EPSDT-PCS POC 1 Form which can be downloaded from the Louisiana Medicaid website~~ included with the prior authorization request. The ~~form~~ plan of care must be completed in its entirety and must specify the personal care task(s) to be provided (i.e., ADLs for which assistance is needed) and the frequency and duration required to complete each of these tasks. Dates of services not included in the POC or services provided before approval of the POC by Healthy Blue are not reimbursable.

The beneficiary’s attending practitioner shall review and/or modify the POC and sign and date it prior to the POC being submitted to Healthy Blue. The POC shall include the following information:

- Beneficiary name, Medicaid ID number, date of birth, address, and phone number;
- Date services are requested to start;
- Provider name, Medicaid provider number and address of personal care agency;
- Name and phone number of someone from the provider agency that may be contacted, if necessary for additional information;
- Medical reasons supporting the need for PCS;
- Other in-home services the beneficiary is receiving;
- Specific personal care tasks (bathing, dressing, eating, etc.) with which the PCS provider is to assist the beneficiary;

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- Goals for each activity;
- Number of days services are required each week;
- Time requested to complete each activity;
- Total time requested to complete each activity each week; and
- Signature of parent/primary caregiver, provider representative and the beneficiary's primary physician.

Amendments or changes in the POC should be submitted as they occur and shall be treated as a new POC which begins a new six (6) month service period. Revisions of the POC may be necessary because of changes that occur in the beneficiary's medical condition which warrant an additional type of service, an increase or decrease in frequency of service or an increase or decrease in duration of service. Documentation for a revised POC is the same as for a new POC. Both a new "start date" and "reassessment date" must be established at the time of reassessment. The provider may not initiate services or changes in services under the POC prior to approval by Healthy Blue.

A new POC must be submitted at least every one hundred eighty (180) days (rolling six (6) months). The subsequent POC must:
- Be approved and signed by the beneficiary's attending practitioner;
- Reassess the beneficiary's need for PCS;
- Include any updates to information which has changed since the previous assessment was conducted; and
- Explain when and why the change(s) occurred.

The POC is acceptable only after the practitioner signs and dates the completed form. The practitioner's signature shall be an original signature and not a rubber stamp.

Changing PCS Providers:
The beneficiary shall be allowed the freedom of choice to select a provider. This freedom also extends to the beneficiary's right to change providers at any time; however, previously approved authorizations are not transferred between agencies. If a beneficiary elects to change providers within an authorization period, the current agency must notify Healthy Blue of the beneficiary's discharge, and the new agency must obtain their own authorization through the usual authorization process.

Provider and Staff Requirements:
Personal care services must be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. Agencies shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by Federal, State and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, Occupational Safety and Health Administration (OSHA) requirements, liability

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insurance, Worker's Compensation, occupational licenses, etc. Agencies shall comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. PCS shall only be provided to EPSDT beneficiaries and only by a staff member of a licensed and enrolled provider. Medicaid enrollment is limited to providers located in Louisiana and certain out-of-state providers located only in the trade areas of Arkansas, Mississippi, and Texas. The licensed agency is responsible for ensuring that all direct service workers providing PCS meet all training requirements applicable under State law and regulations. Individuals who provide coverage in the PCS worker's absence must meet all staffing requirements for the PCS worker or supervisor.

Providers must conduct criminal background checks on the direct care and supervisory staff. A worker may be assigned to provide services to a beneficiary prior to the results of the criminal background check under the direct supervision of a permanent employee or in the presence of a member of the immediate family of the beneficiary or a caregiver designated by the immediate family of the beneficiary as outlined in R.S. 40:1300.52(C)(2). If the results of any criminal background check reveal that the employee was convicted of any offenses as described in R.S. 40:1300.53, pursuant to the statutory revision authority of the Louisiana State law institute, the employer shall not hire or may terminate the employment of such person.

EPSDT-PCS services shall be provided by an individual who meets the following qualifications:

- Must be at least 18 years of age at the time the offer of employment is made;
- Must have the ability to read and write in English as well as to carry out directions promptly and accurately; and
- Must pass a criminal background check.

Staff assigned to provide PCS shall not be a member of the beneficiary's immediate family. Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the beneficiary. PCS may be provided by a person of a degree of relationship to the beneficiary other than immediate family only if the relative is not living in the beneficiary's home, or if he/she is living in the beneficiary's home solely because his/her presence in the home is necessitated by the amount of care required by the beneficiary.

Record Keeping:

Providers must maintain case records for all PCS beneficiaries and personnel records on all supervisory and direct care staff. Records must be complete, accurately documented, readily accessible, and organized. All records must be retained for a period of six (6) years. Billing records must be maintained for a period of six (6) years from the date of payment.

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Any error made in a beneficiary's or employee's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a beneficiary's or employee's record.

There must be a clear audit trail between the:

- Prescribing practitioner;
- PCS provider agency;
- Person providing the PCS to the beneficiary; and
- Services provided and reimbursed by Medicaid/Healthy Blue.

Providers must provide reasonable protection for beneficiary records against loss, damage, destruction, and unauthorized use. A provider must have a separate written record for each beneficiary that includes:

- Copies of all POC, social assessments, EPSDT-PCS Form 90, EPSDT-PCS Daily Schedule ~~Forms~~, and practitioner's order/prescription for EPSDT-PCS;
- Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the POC including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results;
- Documentation of approval of services; and
- Documentation of the provision of services by the PCS worker including signed daily notes by the worker, and supervisor if appropriate, that include:
  - Date of service;
  - Services provided (checklist is adequate);
  - Total number of hours worked;
  - Time period worked;
  - Condition of beneficiary;
  - Service provision difficulties;
  - Justification for not providing scheduled services; and
  - Any other pertinent information.

Providers must make beneficiary and personnel records available to Healthy Blue, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for Healthy Blue, LDH, or its designee.

Electronic Visit Verification:

Healthy Blue requires PCS and home health care providers to use the State-contracted electronic visit verification (EVV) system, the Louisiana Service Reporting System (LaSRS), as directed by LDH to electronically report begin and end time (i.e., clock-in and clock-out) for PCS. Utilization of an EVV system is a federal requirement that applies to all managed care PCS providers. In accordance with the 21st Century Cures Act, LDH collects the following

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identifiable information for Home and Community-Based Services (HCBS) waiver and Louisiana Medicaid State Plan services through LaSRS:

- The type of service performed;
- The enrollee receiving the service;
- The date of the service;
- The location of service delivery;
- The individual providing the service; and
- The time the service begins and ends.

EVV is a web-based system that electronically verifies service visit occurrences and documents the precise time services begin and end via smart devices. LaSRS does not “track” direct service workers – it only collects the location of service delivery at the time of clock-in and clock-out. LaSRS can be accessed by devices with internet connectivity (e.g., computer, smartphone, or tablet). When a worker “clocks-in” or “clocks-out,” the system collects the location of the device being used at that time, as well as the time, date, individual providing the service, and the individual receiving the service. The intent of the system is to verify and help ensure that individuals are receiving the services authorized in the POC, reduce inappropriate billing/payment, safeguard against fraud, replace paper timesheets, and improve program oversight. Healthy Blue must require its providers to use LaSRS. Agencies shall use the EVV system for time and attendance tracking and billing for Healthy Blue may withhold or deny reimbursement for services if a provider fails to use the EVV system or uses the system not in compliance with Medicaid’s policies and procedures for EVV.

REFERENCES:

- Continuity of Care – LA
- Health Plan Advisory 20-10
- Health Plan Advisory 20-13
- Informational Bulletin 19-2
- Informational Bulletin 19-13
- Informational Bulletin 20-12
- Louisiana Medicaid Managed Care Organization Contract
- Louisiana Medicaid Managed Care Organization Manual
- Louisiana Medicaid Pediatric Day Health Care Provider Manual
- Louisiana Medicaid Personal Care Services Provider Manual
- Louisiana State Contract
- Managed Care Organization (MCO) Manual – LA
- Pediatric Day Health Care Prior Authorization Checklist
- Utilization Management – LA

Form(s):

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- EPSDT-PCS Daily Schedule
- EPSDT-PCS Form 90
- EPSDT-PCS Plan of Care
- EPSDT-PCS Social Assessment
- PDHC Prior Authorization Checklist
- Physician's Order for PDHC and PDHC Plan of Care Form

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management – Utilization Management

Secondary Department(s): Health Care Management – Case Management
Operations- Claims
Provider Network and Relations

EXCEPTIONS:

All service authorization processes and procedures are consistent with 42 CFR §438.210, 42 CFR Part 441, Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Gee for initial and continuing authorization of services. Refer to *Prior Authorization Liaison (PAL) Policy – LA* for Chisholm requirements.

The services listed below are typically not reimbursed by commercial health plans. Managed Care Organizations (MCOs) are to accept claims billed directly from the provider without requiring an explanation of benefits from the primary carrier and pay as primary payer.

- EPSDT-PCS Procedure Code: T1019
- PDHC Procedure Code(s): T1025, T1026, and T2002

Long Term-PCS (LT-PCS) for those ages twenty-one (21) and older is an excluded service. Excluded services are those services that members may obtain under the Louisiana State Plan or applicable waivers, and for which Healthy Blue is not financially responsible. However, Healthy Blue is responsible for informing members on how to access excluded services providing all required referrals and assisting in the coordination of scheduling such services.

REVISION HISTORY:

Review Date	Changes
11/12/2018	• New
12/09/2019	• Annual review; • Updated to new template • Revisions made throughout for New LA Emergency Contract

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Review Date	Changes
	• Edits to policy, definitions, procedure, exceptions, and reference sections • Claims and HCM – CM added as Secondary Departments
07/19/2021	• Annual Review • Updated to reflect Contract Amendment 3 effective 12/1/2020 • Updated "recipient" references to "beneficiary" when in alignment with LDH resources • Updated the policy, definitions, procedure, exceptions, and references
07/08/2022	• Annual Review – no content changes • Moved exceptions to correct place on template
10/26/2022	• Off-Cycle Review • Revised for RFP Model Contract Readiness Review • Minor updates to policy and exceptions • Updated definitions and procedure • Alphabetized and updated references; added forms • Removed claims as secondary dpt; Added Operations- Claims and Provider Network and Relations as secondary dpts.
07/19/2023	• Annual Review • Updated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Definition • Procedure and Exceptions sections updated • Removed verbiage for COVID health plan advisories • Removed Chronic Needs Case verbiage • Updated policy to align with current provider manual language
02/21~~0~~/2024	• Off-Cycle Review ~~Updates to PDHC and PCS procedure~~ • Updated Procedure section ~~–~~to align with LDH Alert #51232 Information Bulletin 24-5 ~~-~~ • Updates to PDHC and PCS procedure - Added Chronic Needs Case verbiage to PCS • ~~Added Chronic Needs Case verbiage~~

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